
**Association of American Medical Colleges
Statement on the Value of Academic Affiliations
Submitted to the National Academic Affiliations Council by
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Mr. Chairman, members of the National Academic Affiliations Council, thank you for the opportunity to speak with you today on the value of academic affiliations.

I am Dean Emeritus of Texas A&M College of Medicine, one of the 5 medical schools created in conjunction with established VA Medical Centers by the 1971 Teague-Cranston Act, former Chancellor for Health Sciences at West Virginia University and President Emeritus of the West Virginia University Health System. My specialties are Geriatric Psychiatry and Preventive Medicine. I have cared for veterans throughout my career in medicine.

I am here today as the senior advisor to the Association of American Medical Colleges on Veterans Affairs.

As you likely know, the AAMC is a non-profit comprised of all 147 accredited U.S. M.D.-granting medical schools and nearly 400 major teaching hospitals, including 51 VA medical centers.

The important relationship between the VA and academic medicine dates to the end of World War II when, under Memorandum #2, the VA established the authorization for VA-academic affiliations. Today, the VA has over 500 academic affiliations, and 127 VA facilities have affiliation agreements for physician training with 135 U.S. medical schools.

I sincerely believe that history preordains our shared future. I choose the term preordained for specific reasons. This relationship has been based upon our shared and historical commitment to serve veterans through clinical care, education and research. This relationship was not predestined at the outset the government's commitment to veterans' health care, nor was it particularly predicted. It was a conscious decision made by leaders at the time, and it is our preordained obligation to respect their wisdom.

That being said, we should not be bound by how things have been done in the past. Thoughtful innovation is required to advance our relationship values and to meet the current and future needs of veterans.

My comments today will focus on three vital areas that define the VA-academic medicine relationship: patient care, education and workforce, and research.

Patient Care

In many ways the mission of the VA care delivery system has always been "population health focused." Veterans, as individuals and as a group and their immediate families, have been the focus of care for their unique clinical needs.

Out of this population-focused mission, the VA has become health care's leader and innovator on conditions prevalent in the veteran population, such as TBI, PTS, polytrauma rehabilitation, chronic disease management, aging and neuropsychiatric illnesses.

In a similar fashion, the nation's academic medical centers (AMCs) have also grown and matured over the years to become dynamic clinical centers that provide a disproportionate share of specialized services for medically complex populations, including veterans.

Over the years the relationship among regional VAs and AMCs has been synergistic, despite local challenges that may periodically arise.

Moving forward, the AAMC believes that we need to build upon that synergy. For example:

- Many regional VAMCs, particularly smaller and geographically rural VAMCs, neither have the budgetary strength, patient volumes or human capital to invest in high end specialty care services to achieve comparable outcomes observed in civilian AMC programs.
- Like with commercial and managed care organizations that preferentially contract with AMCs to ensure that their beneficiaries receive top line care, we support contracting mechanisms between VAs and AMCs that enhance optimum resource utilization and contracting ease and consistency.
- Specifically, it is important to retain direct sole source contracting with affiliates which will keep affiliates as an immediate extension of VA care (e.g., “Core Network”). We also recommend streamlining contracting by reducing bureaucratic hurdles, establish pre-approved national templates, and set standardize overhead rates.
- This approach is advantageous for larger VAMCs that care for more complex patients and that are co-located with major teaching hospitals, with shared faculty and residents. For these specific situations, new models for sharing clinical, technological and physical plant resources are needed in order to optimize shared infrastructure investment, ensure patient volumes to maximize clinical outcomes and constrain unnecessary duplication of costs.
- Examples of shared programmatic investment include high-end specialty care, such as critical/trauma services, high end cardiovascular and stroke services, transplant services, and oncology services.

While the AAMC endorses increases in Veteran’s access to civilian health care services through mechanisms like the Veterans Choice Program, without careful care management to support the individual veteran’s navigation of the 21st century health care system, veterans may miss out on access to the very best care available. In addition “unfettered” provider choice by veterans could disrupt the two other important missions of the VA-academic medicine relationship, e.g., education/training and impactful research.

Education and Workforce

The VA has been committed to medical education since WWII, and the nation’s academic medical centers are grateful for that support.

The VA, and thus veterans, has greatly benefited from this relationship, most notably through the recruitment of high quality physician faculty that are integral to the clinical staff of the VA.

Under the supervision of faculty, medical students, health professions students, residents and fellows provide substantial and invaluable direct patient care to veterans.

The VA patient-learner dyad is also a cultural anchor for many young physicians and health professionals who have never served in the nation’s armed forces. Thus, their VA rotations expand their empathic understanding of what it means to “serve and sacrifice” for the nation.

But we are in an era where support of medical and health professions education is challenged.

Failure to address educational support will have a downstream impact on the nation's and the VA's workforce, which is made more challenging today because of physicians of my era are retiring and work-life balance expectations among younger physicians are changing.

For example, by 2030, AAMC projects a nationwide shortage of physicians between 40,000 and 105,000.

Workforce projections within the VA predict similar shortages in coming years, even with the adoption of new models of care that emphasize team based care.

The VA has certainly stepped up to the GME challenge. In 2014, the Veterans Choice Act authorized 1,500 new VA GME positions, and has been the only Federal agency to expand GME funding since the implementation of Medicare's 1997 residency cap.

The VA has met with great success, filling about 50% of the positions targeted in primary care and mental health with another 5-year authorization in order to finish standing up these positions.

However, from the perspectives of funding, accreditation, and workforce development, the VA cannot do it alone.

While many, if not all, major teaching academic affiliates have also increased funding for GME, we need a coordinated effort by all parties to expand GME funding.

The AAMC also recommends specific approaches to address future VA physician recruitment and retention. For example:

- VA specific Medical Student Loan Repayment programs, similar to what has been adopted by the DOD and NHSC.
- Expanding the use of the *Conrad State 30 J-1 Visa Waiver Program*
- Partnership with the Uniformed Services University of Health Sciences and Public Health Service for specific allocation of medical student slots.
- There may be other remedies that are actionable, and as such the AAMC encourages the NAAC to provide additional thought and offer recommendations to address training, recruitment and retention efforts for the VA.

Research

Intramural research for specific conditions seen in the veteran population is uniquely important, and the close relationship and proximity among teaching VA medical centers and AMCs creates a culture of research curiosity, innovation, and the ability to attract leading physician educators and researchers to the VA.

Today's VA research portfolio is robust and ranges from basic and clinical studies in Alzheimer's disease, advanced prosthetics, studies in genomics through the Million Veteran Program, interventions for chronic pain, cardiology, diabetes, and improved treatments for PTSD and other mental health challenges in Veterans such as suicide prevention.

These studies and their findings are impactful for Veterans, and significantly influence the health of all Americans.

The AAMC strongly believes funding for VA research must be steady and sustainable to meet current commitments while allowing for innovative scientific growth to address critical emerging needs.

To that end, the AAMC endorses the Friends of VA Medical Care and Health Research and the Veterans Services Organizations' *Independent Budget* recommendation of \$713 million for VA Medical and Prosthetic Research in FY 2018, a \$38 million (5.6 percent) increase over the FY 2017 comparable level.

The AAMC also supports the VA's clear need for research infrastructure support to upgrade, replace and make research compliant its complement of research facility system wide.

And, the AAMC supports expanded use of VA sole source lease agreements to support shared use of research space with their AMC affiliates.

Conclusion

Since the end of WWII, the VA and academic medicine have synergistically partnered to improve veterans' health through delivery of complex clinical care; medical and health professional education; and collaborating on veteran-centric research designed to positively impact veterans' health.

This is a time of great opportunity for the VA and academic medicine to reaffirm our preordained commitment to serving those who have served this nation.

Thank you and I look forward to your questions.